Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #99.078
OPL99.078

Date: January 25, 1999

Subject: Reporting Requirements for Medicare Managed Care Organizations in 1999: Health Plan Employer Data and Information Set (HEDIS® 1999) Measures that Include the Medicare Health Outcomes Survey (HOS) [Formerly the Health of Seniors Survey] and the Medicare Consumer Assessment of Health Plans Study (CAHPS™ 2.0H)

Important Changes from 1998

This OPL provides information regarding the 1999 Medicare HEDIS submission and provides clarification for Medicare contracting organizations that are converting to Medicare +Choice (M+C), those who are not converting and those organizations that are terminating their contracts or are non-renewing parts of their service areas. Since this OPL covers a year of transition from Section 1876 to Balanced Budget Act provisions, it contains terms relating to both programs. The following changes are also noted:

HCFA will not require MCOs to report HEDIS 1999 data if the MCO's first Medicare enrollment occurred on February 1, 1998 or later. (See I.C.6)

HCFA will administer CAHPS in the Fall of 1999. (See IV.B)

HCFA requires submission of both summary and patient-level HEDIS data on June 30, 1999. (See II.A.)

HCFA will not pay for or arrange for the Medicare HEDIS audit. Medicare Managed Care Organizations (MCOs) must contract with an NCQA-licensed, HEDIS audit organization to conduct the audit of their Medicare data and the site visit team must be led by an NCQA certified HEDIS Compliance Auditor. (See II.B.2)

The Medicare audit for 1999 will audit nine measures on site. Similar to last year, HCFA will require a partial NCQA Compliance audit. HCFA may present a subset of these measures to beneficiaries through its *Medicare Compare* Internet site and *Medicare & You* handbook. (See II.B.1 and Attachment III)

MCOs will receive only one Detail Report from NCQA, for informational purposes only, after NCQA has uploaded the submission into its database. In previous years MCOs have

received two reports. As always, MCOs may not change their data after the submission date. (See II.A.1)

The Health of Seniors Survey has been renamed the Medicare Health Outcomes Survey (HOS).

Background

Effective January 1, 1997, HCFA began requiring MCOs to report on performance measures from the HEDIS reporting set relevant to the Medicare managed care population, and to participate both in CAHPS and the HOS survey-based HEDIS measure. This OPL explains 1999 reporting requirements for HEDIS 1999, HOS, and CAHPS and addresses specific HCFA requirements regarding how health plans must implement HEDIS 1999, HOS, and CAHPS.

These requirements are consistent with HCFA's regulatory/statutory authority and contract terms with health plans to obtain the information necessary for proper oversight of the program. It is critical to HCFA's mission that we collect and disseminate information that will help beneficiaries choose among health plans, contribute to better health care through identification of quality improvement opportunities, and assist HCFA in carrying out its responsibilities.

HCFA will make summary, plan-level performance measures available to the public through media that is beneficiary oriented, such as the *Medicare Compare* Internet site and the *Medicare & You* handbook. A subset of HEDIS and CAHPS data will also be available in printed form through a toll free line. Additionally, information may be released at a more technical level, such as releasing raw HEDIS data and the results of research using these data.

Please note that if there are differences between this policy letter and the HEDIS 1999 document, this OPL takes precedence for reporting data. The final HEDIS 1999 Volume 2: Technical Specifications is available from NCQA. Please call NCQA Publications at 1-800-839-6487 to obtain a copy. Download periodic corrections to Volume 2 from the NCQA web site: www.ncqa.org/hedis/h99cor.htm .

Contact: HCFA Regional Office Managed Care Staff

This OPL was prepared by the Center for Health Plans and Providers

PROGRAM REQUIREMENTS

1999 Contract year	Sampling Frame/ Period	Dates for Participation Eligibility	Minimum Sample Size	Market Area Reporting	Financial Responsibility	Demon-strations	Mergers and Acquisitions	Cost Contract Reporting	Due Dates
HEDIS 1999 and HEDIS 1999 audit	Services delivered in 1998 (and earlier for some measures)	First Medicare Enrollment on 1/1/98 or earlier (i.e. plans with initial Medicare enrollment on 2/1/98 or later are exempt.)	Measure specific (MCOs must report all Medicare measures according to instructions)	Yes	MCO pays for external HEDIS Audit	Yes, as specified at section I.C.10 below	Reporting by acquiring MCO (reporting of effectiveness of care measures only for nonsurvivor)	Report Cost Contract Measures	MCO must submit Audited Summary and Patient-Level Data by June 30, 1999.
Health Outcomes Survey	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 1/1/98; PACE demos with contract as of 1/1/99	1000 (If less than 1000 enrollees, all members must be surveyed.)	Yes	MCO pays for vendor to administer survey	Yes (See section I.C.10)	Reporting of surviving MCO's membership only	Yes	MCO must arrange to administer survey in March 1999.
CAHPS	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 7/1/98	600 (If less than 600 enrollees, all members will be surveyed.)	Yes	HCFA pays for survey administration	Yes (See section I.C.10)	Reporting of surviving MCO's membership only	Yes	HCFA will administer survey in Fall 1999.

IMPLEMENTING HEDIS 1999 MEASURES AND MEDICARE CAHPS

I. Specifics Applicable to CAHPS and HEDIS

A. Effects of the Balanced Budget Act of 1997

The Balanced Budget Act of 1997 established Part C of Medicare, known as the Medicare+Choice (M+C) program which will replace the current program of risk and cost contracting generally starting with contracts effective beginning January 1, 1999. The reporting requirements contained in this OPL apply to organizations that held Section 1876 risk or cost contracts during the calendar year of 1998 AND that either signed a contract to be a M+C organization in 1999 or that have a continuing contract under section 1876 as a cost-contracting entity. Please see section C below for exceptions to this requirement, such as organizations that have terminated their section 1876 contract with HCFA for 1999 or have reduced their service areas for 1999. Reporting authority pertaining to organizations contracting under the M+C program is found at 42 CFR 422.152.

B. M+C MCOs or Continuing Cost Contractors

1. Reporting Requirements

a. HEDIS 1999: A MCO must report HEDIS 1999 measures for their Medicare managed care contract(s), as detailed in the *HEDIS 1999 Volume 2: Technical Specifications* if:

the contract was in effect on 1/1/98 or earlier;
the contract had initial enrollment on 1/1/98 or earlier;
the contract has been continued for the service area or a successor M+C contract has been obtained.

In other words, MCOs with a contract effective date of January 1, 1998 or earlier but with no initial enrollment on 1/1/98 or before do not have to participate in HEDIS reporting in 1999. The Medicare relevant measures in HEDIS 1999 that M+C MCOs must report are listed in Attachment I, and the Medicare relevant measures in HEDIS 1999 that continuing cost contractors must report are listed in attachment I.A.

b. Health Outcomes Survey: All M+C MCOs and continuing cost contractors that had a Medicare contract in effect on or before January 1, 1998, must comply with the HOS requirements during 1999.

Program of All Inclusive Care to the Elderly (PACE) plans approved by HCFA on or before March 1, 1999 must participate in the Health Outcomes Survey.

c. Medicare CAHPS: All M+C MCOs and continuing cost contracts that had a Medicare contract in effect on or before July 1, 1998, must comply with the CAHPS survey requirements during 1999.

Medicare CAHPS does not apply to M+C MCOs that received a contract effective after July 1, 1998. However, such MCOs may be required to undertake an enrollee satisfaction survey during 1999 to comply with the HCFA regulations on physician incentive plans (Vol. 61, Federal Register, 13430, March 27, 1996). Plans may wish to use Medicare CAHPS for this purpose.

2. No Minimum Size Requirement: There is no minimum size requirement for MCOs to report HEDIS 1999 measures or participate in the HOS and Medicare CAHPS surveys. When an MCO has fewer beneficiaries enrolled than the CAHPS sample size of 600 or the HOS sample size of 1,000, the entire membership must be surveyed.

An MCO must report all Medicare HEDIS measures, even if the MCO has small numbers for the denominator of a measure. Specific Guidelines for Effectiveness of Care Measures, Access/Availability of Care Measures, and Use of Services Measures in the *HEDIS 1999 Volume 2, Technical Specifications* (Pages 3, 33, 127, and183) discuss NCQA's new requirement on reporting for small numbers. For audited measures, a determination of rate suppression due to small sample numbers, *e.g.* "NA", will be made by the MCO's HEDIS auditor. For those measures not being audited, appropriate suppression for small denominators will be handled through the data submission process.

3. Sampling and Reporting Unit: The "contract-market" is the reporting unit for HEDIS, CAHPS, and HOS and implies either reporting by contract or by a market area within a contract. MCO's must report once for each contract unless HCFA divides the contract service area into "market areas." When the contract service area is subdivided, the resulting market areas cover more than one major community or city and each market area has at least 5,000 Medicare enrollees. In these situations, MCOs will report two or more sets of data for a given contract. This approach will provide more meaningful information to beneficiaries, plans, and HCFA. There are no exceptions to reporting by market area where applicable.

HCFA will assess all contract service areas to determine whether the HMO must report by market area. HCFA will notify plans whether they must report by market area and will identify the geography of each market area. MCOs that are not notified of market area reporting will report by contract.

Attachment I identifies the HEDIS 1999 measures by the level of reporting for each required measure: legal entity, contract, or market area (if applicable).

C. M+C Plans with Special Circumstances

1. MCOs with Multiple Contracts: **A MCO cannot combine small contracts or designated market areas into a larger reporting unit.** An MCO with multiple Medicare contracts must report HEDIS 1999, CAHPS, and HOS surveys for each section 1876 risk and cost contract held in 1998. HCFA will notify plans as soon as possible whether they must report by market area.

2. MCOs Carrying Cost or HCPP Members: HEDIS performance measures will be calculated using only the Medicare enrollment in the section 1876 contract in effect at year end 1998. Therefore, the following beneficiaries should not be included in HEDIS calculations.

(1) any residual cost-based enrollees of a section 1876 risk contract
(2) any residual HCPP enrollees of a section 1876 cost contract

For HEDIS measures with a continuous enrollment requirement and for enrollees who converted from one type of contract to another (with the same organization), enrollment time under the prior contract will not be counted.

The CAHPS and HOS surveys will not include these cost members remaining from prior contracts.

3. MCOs with New Members "Aging-in" from Their Commercial Product: MCOs with members "aging into" their Medicare product from their commercial product must consider those members eligible for performance measure calculations assuming that they meet any continuous enrollment requirements. That is, plan members that switch from a MCO's commercial product to the MCO's Medicare product are considered continuously enrolled. Please see pg. 14 of *HEDIS 1999 Volume 2: Technical Specifications* for a discussion of "age-ins" and continuous enrollment requirements.

4. MCOs with Changes in Service Areas: MCOs that received approval for a service area expansion during the 1998 contract year and those that will be reducing their service area effective January 1, 1999 must include information regarding those beneficiaries in the expanding or reducing areas based on the continuous enrollment requirement and use of service provisions of the particular measure being reported.

5. HMOs with Home and Host Plans: The home plan must report the data related to services received by its members when out of the plan's service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan's contract with HCFA. The home plan is responsible for assuring that the host plan fulfills the home plan's obligations. Plan members that alternate between an MCO's visitor plan and the home plan are considered continuously enrolled.

6. New Contractors: MCOs with initial enrollment on February 1, 1998 or later will not report HEDIS 1999 performance measures for calendar year (CY)1998. However, these plans

must have systems in place to collect performance measure information so that they can provide reliable and valid HEDIS data in 2000.

7. Non-renewing/Terminating MCOs: Entities that meet the HEDIS reporting requirements stated above but who have terminated their section 1876 contracts effective December 31, 1998 and have not signed a successor contract for that contract service area under the M+C program will not be required to submit HEDIS data in 1999 for CY 1998 or participate in the HOS or CAHPS survey.

8. MCOs with Continuing Section 1876 Cost Contracts: For cost contracts, HCFA has modified the HEDIS measures to be reported. Cost contractors will not report the Use of Services inpatient measures. The measures to be reported are listed on Attachment I.A. HCFA does not require cost contractors to report inpatient (e.g., hospitals, SNFs) measures because MCOs with cost-based contracts are not always responsible for coverage of the inpatient stays of their members. Cost members can choose to obtain care outside of the plan without authorization from the MCO. Thus, HCFA and the public would not know to what degree the data for these measures are complete.

Cost contracts will provide patient-level data for all the HEDIS Effectiveness of Care and the Use of Services measures for which they submit summary level data. (See Attachment I.A and III.)

9. Mergers and Acquisitions: HCFA has determined that the entity surviving a merger or acquisition shall report both summary and patient-level HEDIS data only for the Effectiveness of Care (EOC) measures listed in Attachment I, except the Medicare Health Outcomes Study, related to the former members of the non-surviving contract(s) [i.e., those contract(s) which have been terminated due to the merger]. This reporting by the surviving entity shall apply if the non-surviving contract was in effect for any part of 1998. Members of the non-surviving contract(s) will not be surveyed under CAHPS and HOS.

The purpose of reporting the six EOC measures for non-surviving contracts is to provide a more complete data base for HCFA and other researchers to explore issues of national interest. However, HCFA will not post this information for plan-to-plan comparisons since the contracts are no longer in effect and thus are not available for beneficiary selection. We recognize that beneficiaries and affiliated providers may be associated with the surviving entity's contract. However, HCFA believes that HEDIS measures based on the combined 1998 membership and providers of both contracts could be misleading since the management, systems, and quality improvement interventions related to the non-surviving contract are no longer in place. Reported results based on combined contracts may not reflect the quality of care or medical management available under the surviving contract.

The surviving contract(s) must comply with all aspects of this OPL for all members it had in 1998.

10. Demonstration Projects: HCFA also requires many demonstrations with section 1876 contracts or similar contracts to meet the HEDIS, CAHPS or HOS reporting requirements. Some demonstrations may not be subject to all requirements; the reporting requirements for each demonstration type are listed in the chart below. Demonstrations should discuss any modifications to the requirements in this OPL with their HCFA project officer. Other demonstration projects not identified here do not have to report HEDIS, CAHPS or HOS.

Demonstration	HEDIS 1999	HEDIS Audit	CAHPS	HOS
Social HMOs	Yes	Yes	Yes	Yes
Medicare Choices	Yes	Yes	Yes	Yes
Minnesota LTC	Yes	No	No	No
Evercare	Yes	No	No	Yes
PACE	No	No	No	Yes

D. Implications for Failure to Comply

HCFA expects full compliance with the requirements of this OPL. MCOs must meet the time lines, provide the required data, and give assurances that the data are accurate. Plans which do not comply may be subject to sanctions as provided for under BBA in section 1857(g) and in regulations at 422.752(b).

E. Use of Data

Data reported to HCFA under this requirement will be used in a variety of ways. The primary audience for the HEDIS, CAHPS, and HOS summary data is the Medicare beneficiary. These data will provide comparative information on contracts to beneficiaries to assist them in choosing among contracts. In addition, HCFA expects MCOs to use the data for internal quality improvement. Each MCO's summary HEDIS 1999 and Medicare CAHPS data will be arrayed and returned to them. The data should help MCOs identify some of the areas where their quality improvement efforts need to be targeted. Further, the data will provide HCFA and Peer Review Organizations with information useful for monitoring the quality of, and access to, care provided by MCOs. HCFA may target areas that warrant further review based on the data.

II. HEDIS 1999 Requirements

A. Summary and Patient-Level Data

HCFA is committed to assuring the validity of the summary data collected, before it is released to the public, and to make the data available in a timely manner for beneficiary information. **MCOs must submit HEDIS 1999 summary measures after completing the partial NCQA HEDIS Compliance Audit™ required by Medicare by June 30, 1999. MCOs must submit HEDIS patient-level data by June 30, 1999.** HCFA is requiring the submission of patient-level data on the same date as summary data to ensure that the patient-level data matches the summary data. In 1998, several MCOs discovered discrepancies between their patient-level and summary data after submitting their HEDIS 3.0/98 summary data.

Please note that auditors will review patient-level data for the numerator and denominator of all audited measures when checking for algorithmic compliance during the HEDIS audit. (See *HEDIS 1999 Volume 5: HEDIS Compliance Audit: Standards, Policies, Procedures* for more information on the audit process.)

1. Summary Data

a) *Required Measures*: MCOs that held 1876 risk contracts in 1998 and subsequently entered an M+C contract must report summary data for all required HEDIS 1999 measures identified in Attachment I, except for the Health Outcomes Survey measure (see discussion below at III). M+C MCOs that held section 1876 cost contracts and continuing cost contracts must report summary data for all HEDIS 1999 measures identified in Attachment IA. **Please note that if there are differences between this policy letter and the HEDIS 1999 document, this OPL takes precedence for reporting data.**

The HEDIS measures Flu Shots for Older Adults and Advising Smokers to Quit are collected through the CAHPS survey instrument. For those MCOs for which HCFA is not administering the CAHPS survey, due to cutoff dates for identifying the 1998 samples, this smoking cessation and flu shot information will not be collected.

As noted in the technical specifications, MCOs must attempt to produce every Medicare required measure, and report a numerator and denominator even if the numbers are small, *i.e.* the denominator is less than 30. (See *HEDIS 1999 Volume 2: Technical Specifications* page 8.)

b) *Data Submission*: The summary data for all HEDIS 1999 measures must be sent to NCQA, HCFA's contractor for the collection of data by June 30, 1999. Specifications for calculating the summary measures are available in the *HEDIS 1999 Volume 2: Technical Specifications,* which is available from NCQA. Please call NCQA Publications at 1-800-839-6487 to obtain a copy.

NCQA's 1999 Data Submission Tool (DST) for collecting HEDIS summary measures will be a modification of the 1998 DST. The DST is based on Excel 7.0. Health plans must use this standardized submission tool to report HEDIS 1999 data and should make sure that they have sufficient computing capability to run the DST. NCQA will provide health plans with a DST in

the spring of 1999. Specifics regarding the data submission tool and the submission process will be forthcoming from NCQA.

As in previous years, MCOs will not be allowed to change to their data after submission to NCQA. The upgraded DST will allow MCOs to print a hard copy of the DST and review all rates prior to submission. In addition, MCOs will review audited measures with their auditor in detail and submit the audit opinion with their HEDIS submission. MCOs will receive one feedback report (called "Detail Report") from NCQA after submission for informational purposes only.

2. Patient-Level Data

Analysis of data with patient-level identifiers for the numerator and denominator of each measure allows HCFA to match HEDIS data to other patient-level data for special projects of national interest and research, such as an assessment of whether certain groups (*e.g.* ethnic, racial, gender, geographic) are receiving fewer or more services than others. These analyses will not be used for public plan-to-plan comparisons.

(a) *Required Measures*: MCOs must provide patient-level data identifying the contribution of each beneficiary to the denominator and numerator of every required summary measure on beneficiaries and each beneficiary's months of enrollment. Attachment II lists the clinical Effectiveness of Care process measures (excluding the Health Outcomes Survey measure) and the Use of Services measures for which patient identifiers and member month contributions must be provided. Beneficiaries shall be identified by their individual health insurance claim (HIC) number. The HIC number is the number assigned by HCFA to the beneficiary when he/she signs up for Medicare. MCOs use this number for enrollment accretions/deletions. Attachment II also outlines the specifications for reporting patient-level data.

(b) *Data Submission*: NCQA expects to continue collecting patient-level data as a flat text file and will provide health plans with the record layout in spring of 1999. **Plans must retain data used for reporting for three years.**

All patient-level data are protected from public dissemination in accordance with the Privacy Act of 1974 as amended. There have been questions and concerns expressed about the provision of patient-level data, particularly with regard to behavioral health measures. Plans are accountable for providing patient-level data, unless prohibited by state law. In such cases, plans must provide HCFA with appropriate documentation of the legal prohibition for HCFA's consideration.

B. HEDIS Audit: Certification of Data Accuracy

Because of the critical importance of ensuring accurate data, HCFA continues to require an external audit of the HEDIS measures before public reporting. **Health plans are responsible for submitting audited data for the measures selected by HCFA.** In addition, the plan's senior executive officer or its director of medical affairs will be required to provide written

attestation to the validity of the plan-generated data. The attestation form will be sent with the data collection tool.

1. HCFA Required Measures

HCFA requires that MCO's have nine specific HEDIS measures audited. Please see Attachment III for the list of measures subject to audit in 1999. These are the same measures that HCFA audited in 1998 with the addition of the following measures.

Antidepressant Medication Management
Cholesterol Management After Acute Cardiovascular Events

HCFA will present some number of audited measures on its *Medicare Compare* Internet site and in the *Medicare & You* handbook.

2. Health Plan Initiated Audit

HCFA requires each health plan to contract with an NCQA licensed organization for a partial NCQA HEDIS Compliance Audit and may do so in a way that will coordinate the audit process for all payor sources. The licensed audit firms are listed on NCQA's web site at www.ncqa.org. HCFA will require that the licensed organizations use the NCQA *HEDIS 1999 Volume 5: HEDIS Compliance Audit: Standards, Policies, Procedures.*

Unlike previous years when HCFA paid for the HEDIS audit, health plans are financially responsible for the HEDIS Compliance Audit in 1999.

The health plan must ensure that the site visit audit team is led by a NCQA certified HEDIS Compliance Auditor and that the auditor is present during the site visit.

The summary HEDIS data must be submitted by June 30, 1999 and the nine selected measures must be audited by then.

HCFA has worked closely with NCQA in modifying the 1999 audit program to address our interests, however, we may include a few additional Medicare specific elements. To the extent this is necessary, we will inform health plans and licensed audit organizations as soon as possible.

3. Individual Audit Reports, Use and Release

HCFA will use individual audit reports to support contract monitoring and quality improvement activities. Individual audit reports are subject to the Freedom of Information Act (FOIA). HCFA will follow the FOIA regarding any release of such report and will make a determination about the release of information in each audit report on a case by case basis. Information deemed proprietary by both the MCO and HCFA will not be released.

HCFA will issue an addendum to this OPL early in 1999 outlining specific Medicare Audit requirements for 1999.

III. The Medicare Health Outcomes Survey (HOS) Requirements

The Short Form (SF) 36 supplemented with additional case-mix adjustment variables will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS 1999 functional status measure, Medicare Health Outcomes Survey (HOS). This measure is the first "outcomes" measure for the Medicare population. Because it measures outcomes rather than the process of care, it is primarily intended for population-based comparison purposes, by contract- market. The HOS measure is **not** a substitute for assessment tools that MCOs are currently using for clinical quality improvement. In 1999, 1,000 beneficiaries per contract-market will be surveyed with a targeted response rate of at least 60 percent. If the contract-market has fewer than 1,000 eligible members, all will be surveyed.

All M+C MCOs and continuing cost contracts that held section 1876 risk and cost contracts in 1998, as well as Social HMOs (SHMOs), and Evercare demonstrations with Medicare contracts in effect on or before January 1, 1998 must comply with this survey requirement during 1999. In addition, Program for All-Inclusive Care to the Elderly (PACE) plans with Medicare contracts in effect on or before March 1, 1999 must comply with this survey requirement during 1999. MCOs, **at their expense,** are expected to contract with any of the NCQA certified vendors for administration of the survey. You may begin contracting with vendors on approximately December 1, 1998. Contracts are expected to be in place by February 4, 1999 to ensure survey implementation by early March, 1999. Further details will be provided by NCQA, HCFA's contractor, regarding organizing the survey. To expedite the survey process, MCOs may be asked to provide telephone numbers or verify telephone numbers for the respondents unable to be identified using other means. A process to ensure MCOs do not know which enrollees are survey participants will be developed by HCFA and NCQA.

Since the Health Outcomes Survey measure looks at health status over a two-year period, results from this survey will not be publicly released in 1999. The survey in 2001 will assess the same beneficiaries' health status compared to two years prior. Beneficiaries will be categorized into those who are better, the same, or worse over the two year period. Each contract- market score (the percent of beneficiaries who are better, the same or worse), will be reported in late 2001. See Attachment IV for additional information.

IV. Medicare CAHPS Requirements

A. Update on Round 1 of the 1998 CAHPS

The first round of Medicare CAHPS was completed in Spring of 1998 with a response rate of 74%. All section 1876 risk and cost MCOs with Medicare contracts in effect on or before

January 1, 1996 were included in this survey. Survey results were compiled and presented to the MCOs for their review in Fall 1998. CAHPS survey measures will be released to the public via Medicare Compare in early 1999. Because of MCOs' and HCFA's interest in internal MCO quality improvement activities, HCFA provided each MCO with its own summary data, consistent with the Privacy Act (Title 5, USC, section 552a). These detailed MCO reports were released to the MCOs in early December 1998.

B. Update on Round 2 of the 1998 Medicare CAHPS

In order to initiate an annual CAHPS survey of managed care enrollees every Fall, HCFA conducted the second round of Medicare CAHPS in the Fall 1998. Hereafter, Medicare CAHPS will be administered annually in the Fall.

All section 1876 risk and cost MCOs whose Medicare contracts were in effect on or before January 1, 1997 were required to participate in this administration of the Medicare CAHPS survey. For the second round, the CAHPS survey was administered for all eligible Medicare contract-markets by a single independent contractor.

HCFA selected the sample for each contract-market. Each sample included a random sample of 600 members who had been continuously enrolled in the contract for six months and were not institutionalized. For MCOs with fewer than 600 eligible members, all eligible members were surveyed.

The Medicare CAHPS questionnaire included 80-90 items. The 1998 Medicare Satisfaction Survey differs from the 1997 version in that it represents a merged instrument with NCQA's Member Satisfaction Survey.

In order to achieve a minimum 70 percent response rate, the second round of the survey included two mailings with telephone follow-up of non-respondents. Because HCFA does not have beneficiary telephone numbers, we again asked MCOs to provide us with an electronic transmission that included the HIC number and telephone number for beneficiaries. HCFA provided the MCOs with a list of beneficiaries that consisted of beneficiaries included in the sample but embedded within a larger list of beneficiaries enrolled in the MCO. MCOs were given a choice between providing telephone numbers for all beneficiaries enrolled in the MCO or just beneficiaries on the HCFA list.

Selected results from this survey will be released to the public to facilitate plan-to-plan comparisons. Only data gathered through HCFA's administration will be publicly released. These data will be disseminated to the public via *Medicare Compare* (www.medicare.gov) as well as with the *Medicare & You* mailout.

HCFA will continue to provide the MCOs participating in the HCFA administration of the CAHPS survey with detailed reports for their own internal quality improvement efforts.

C. Information Regarding 1999 CAHPS

In the Fall of 1999, HCFA is planning to administer the third Medicare CAHPS survey. M+C MCOs and continuing cost contracts with contracts in effect on or before July 1, 1998 will be included. Beneficiaries will be eligible for the survey if they have been continuously enrolled for 6 months and are not institutionalized. The survey administration mode for the third round is identical to that of round 2: two mailings with telephone follow-up of non-respondents. We will be requesting telephone numbers from those contracts included in our sample in September 1999 in order to conduct the telephone follow-up of non-respondents. **HCFA will pay for the administration of the survey.**

V. Contacts

1. HEDIS 1999 and HEDIS Audit: Health plans should address all questions or requests for clarifications about the HEDIS 1999 Technical Specifications to NCQA's technical information line (telephone 202 / 955-1737 or E-mail hedis@ncqa.org).

Questions about Medicare HEDIS not resolved through NCQA can be directed to Richard Malsbary at 410-786-1132, Donna Bramlett at 410-786-1218, or Chris Smith Ritter at 410-786-4636 in HCFA's Center for Health Plans and Providers. When contacting HCFA, health plans should be prepared to tell HCFA both the advice that they received from NCQA and the individual at NCQA with whom they spoke.

Questions about the HEDIS audit can be addressed by Dorothea Musgrave at 410-786-1099 in HCFA's Office of Clinical Standards and Quality.

2. HOS: For technical questions regarding the Medicare Health Outcomes Survey, please contact Chris Haffer at 410-786-8764.

3. CAHPS: For technical questions regarding Medicare CAHPS™, please contact Liz Goldstein or Mamatha Pancholi of HCFA's Center for Beneficiary Services at 410-786-6665 and 410-786-3133 respectively.

Attachment I

HEDIS 1999 REQUIRED MEASURES FOR MEDICARE BY CATEGORY OF REPORTING FOR SUMMARY DATA

All MCOs to Report by Legal Entity[1]:
Health Plan Stability
Indicators of Financial Stability

All MCOs to Report by Contract[2]:
Cost of Care
High-Occurrence/High-Cost DRGs
Rate Trends
Health Plan Descriptive Information
Practitioner Compensation

Reporting by Contract or Market Area[3]
Effectiveness of Care
Antidepressant Medication Management (for those with a drug benefit)
Cholesterol Management After Acute Cardiovascular Events
Breast Cancer Screening
Beta Blocker Treatment After A Heart Attack
Eye Exams for People with Diabetes
Follow-up After Hospitalization for Mental Illness
Medicare Health Outcomes Survey

Access to/Availability of Care
Adults' Access to Prevention/Ambulatory Health Services
Availability of Language Interpretation Services, Parts I & II

Health Plan Stability
Years in Business/Total Membership
Practitioner Turnover
Note: Health Plans should not report Disenrollment as HCFA collects this information elsewhere.

Use of Services
Frequency of Selected Procedures
Inpatient Utilization - General Hospital/Acute Care
Ambulatory Care
Inpatient Utilization - Non-Acute Care
Mental Health Utilization - Inpatient Discharges and Average Length of Stay
Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information
Board Certification/Residency Completion
Total Enrollment
Enrollment by Payer (Member Years/Months)[4]

REPORTING CLARIFICATIONS

[1] There is one measure in the Health Plan Stability Domain which all MCOs will report by legal entity. (A legal entity is the licensed organization which contracts with HCFA. This entity submits the balance sheet and other financial reports, for the company, to HCFA as required by federal regulations). If a MCO has more than one contract, data for all contracts will be aggregated in this measure.

[2] There are two measures in the Cost of Care Domain and one measure in the Health Plan Descriptive Information Domain which all MCOs will report by contract.

[3] All remaining measures will be reported by contract or by market area for those MCOs with market areas designated by HCFA.

[4] *Please Note that Table 8D, Data on Enrollment: Percent of Plan's Total Member Months by Payer, Age and Sex must be submitted by contract or*

market area. We will not accept reporting of commercial membership on a plan-wide basis.

Attachment I.A

CONTINUING COST CONTRACTS: HEDIS 1999 REQUIRED MEASURES FOR MEDICARE BY CATEGORY OF REPORTING FOR SUMMARY DATA

All MCOs to Report by Legal Entity[1]:

Health Plan Stability

Indicators of Financial Stability

All MCOs to Report by Contract[2]:

Cost of Care

High-Occurrence/High-Cost DRGs

Rate Trends

Health Plan Descriptive Information

Practitioner Compensation

Reporting by Contract or Market Area[3]

Effectiveness of Care

Antidepressant Medication Management (for those with a drug benefit)

Cholesterol Management After Acute Cardiovascular Events

Breast Cancer Screening

Beta Blocker Treatment After A Heart Attack

Eye Exams for People with Diabetes

Follow-up After Hospitalization for Mental Illness

Medicare Health Outcomes Survey

Access to/Availability of Care

Adults' Access to Prevention/Ambulatory Health Services

Availability of Language Interpretation Services, Parts I & II

Health Plan Stability

Years in Business/Total Membership

Practitioner Turnover

Note: Health Plans should not report Disenrollment as HCFA collects this information elsewhere.

Use of Services

Ambulatory Care

Outpatient Drug Utilization (for those with a drug benefit)

Health Plan Descriptive Information

Board Certification/Residency Completion

Total Enrollment

Enrollment by Payer (Member Years/Months)

REPORTING CLARIFICATIONS

[1] There is one measure in the Health Plan Stability Domain which all MCOs will report by legal entity. (A legal entity is the licensed organization which contracts with HCFA. This entity submits the balance sheet and other financial reports, for the company, to HCFA as required by federal regulations). If a MCO has more than one contract, data for all contracts will be aggregated in this measure.

[2] There are two measures in the Cost of Care Domain and one measure in the Health Plan Descriptive Information Domain which all MCOs will report by contract.

[3] All remaining measures will be reported by contract or by market area for those MCOs with market areas designated by HCFA.

[4] *Please Note that Table 8D, Data on Enrollment: Percent of Plan's Total Member Months by Payer, Age and Sex must be submitted by contract or market area. We will not accept reporting of commercial membership on a plan-wide basis.*

Attachment II

SUBMITTING PATIENT-LEVEL DATA

Required Measures

MCOs must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. MCOs must submit patient-level data by contract- market. The HIC number is assigned by HCFA to the beneficiary when s/he signs up for Medicare, and MCOs use this number for accretions and deletions. In addition to the patient identifier, MCOs also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

The list of required measures for 1999 is the same as 1998 with the addition two new Effectiveness of Care measures (Antidepressant Medication Management and Cholesterol Management After Acute Cardiovascular Events) and the Access/Availability of Care measure: Adults' Access to Preventive/ Ambulatory Health Services. We have dropped the two retired Use of Services measures: Readmission for Selected Mental Health Disorders and Readmission for Chemical Dependency.

Note: Section 1876 cost contracts in 1998 (whether or not they became an M+C MCO in 1999) should only report patient-level data for the summary measures that are listed in Attachment I.A.

Effectiveness of Care:

- Breast Cancer Screening
- Beta Blocker Treatment After A Heart Attack
- Eye Exams for People with Diabetes
- Follow-up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Cholesterol Management After Acute Cardiovascular Events

Access/Availability of Care:

- Adults' Access to Preventive/Ambulatory Health Services

Use of Services:

- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization - Nonacute Care

Mental Health Utilization- Inpatient Discharges and Average Length of Stay
Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
Chemical Dependency Utilization- Inpatient Discharges and Average Length of Stay
Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

To be useful, this patient-level data must match the summary data for the measures discussed here, *i.e.* the patient file should contain all beneficiaries enrolled in the contract at the time that the summary measures are calculated. To ensure an exact match, the MCO should make a copy, or "freeze," its database when the summary measures are calculated. NCQA will provide MCOs with exact file specifications by spring of 1999, which is sufficient time to allow MCOs to identify the best way to fulfill this requirement.

DESCRIPTION OF PATIENT-LEVEL INFORMATION

This attachment describes the type of patient-level information required for each measure. These charts are only meant to communicate the type of information HCFA requires. NCQA will provide MCOs with exact file specifications for submitting data in spring 1999. Please consult the HEDIS Technical Specifications for a complete description of each measure.

The following examples use a fictional contract of 100 members, including beneficiaries HIC1, HIC2, HIC3, and HIC100, to depict the required information. For each member, the MCO must provide three important pieces of information.

HIC Number (Patient Identifier)
Member Month Contribution
Each Member's Contribution (or lack thereof) to Each Measure.

This implies that information should be provided on every contract member for every measure, even if the beneficiary did not contribute to a specific measure. For example, a MCO would indicate for every enrolled male that they had not contributed to the either the denominator for the numerator for the Breast Cancer Screening measure.

The charts below demonstrate how beneficiaries HIC1, HIC2, HIC3, and HIC100 would appear in a database. Unless otherwise specified, a 1 indicates that the MCO counted the individual in the piece of the measure (numerator, denominator) indicated by the column title, and a 0 indicates that the MCO did not count the individual in the measure. NCQA's file specifications will indicate missing value designations.

Member Month Contribution

MCOs must provide the member month contribution for each HIC number.

HIC Number	Member Month Contribution
HIC 1	**12**
HIC 2	**12**
HIC3	**8**
HIC 100	**10**

Effectiveness of Care Measures

MCOs will need to indicate whether a beneficiary contributed to the numerator(s) or denominator for the Beta Blocker After Heart Attack, Eye Exams for People with Diabetes, Antidepressant Medication Management, and Cholesterol Effectiveness of Care measures similar to the Breast Cancer Screening example below. In the example below, HIC3 and HIC100 could be men, women with a bilateral mastectomy, or women over age 69 years.

HIC Number	Denominator Breast Cancer Screening	Numerator Breast Cancer Screening
HIC 1	**1**	**0**
HIC 2	**1**	**1**
HIC3	**0**	**0**
HIC 100	**0**	**0**

For the Follow-up After Hospitalization for Mental Illness measure, instead of reporting whether or not an individual contributed to a measure (1 or 0), MCOs should report the total number of valid discharges and follow-ups for each beneficiary. HIC1 had two discharges for mental illness but only one follow-up within 30 days after discharge but not in the seven days immediately following discharge. Please see the *HEDIS 1999 Volume 2: Technical Specifications* to determine which discharges and follow-ups should be counted.

HIC Number	Denominator Follow-up after Mental Illness	Numerator Follow-up after Mental Illness (7 days of discharge)	Numerator Follow-up after Mental Illness (30 days of discharge)
HIC 1	**2**	**0**	**1**
HIC 2	**0**	**0**	**1**
HIC3	**0**	**0**	**0**
HIC 100	**1**	**1**	**1**

Access/Availability of Care Measures

Adults' Access to Ambulatory/Preventive Health Services

MCOs must report how each beneficiary contributed to the calculation of the numerator or denominator for each age group. In the example below, HIC1 is between age 20 and 44 and had at least one ambulatory/preventive care visit, HIC2 is between ages 45 and 64 and had at least one ambulatory/preventive care visit, and both HIC3 and HIC100 are over 65, with HIC3 experiencing at least one ambulatory/preventive care visit.

HIC Number	Denom-inator Adults' Access 20-44	Numer-ator Adults' Access 20-44	Denom-inator Adults' Access 45-64	Numer-ator Adults' Access 45-64	Denom-inator Adults' Access 65+	Numer-ator Adults' Access 65+
HIC 1	**1**	**1**	**0**	**0**	**0**	**0**
HIC 2	**0**	**0**	**1**	**1**	**0**	**0**
HIC3	**0**	**0**	**0**	**0**	**1**	**1**
HIC 100	**0**	**0**	**0**	**0**	**1**	**0**

Use of Services

Frequency of Selected Procedures

MCOs must provide the numerator information for all the procedures listed under the Frequency of Selected Procedures Measure. MCOs should report the total number of times a beneficiary received each procedure. In this example, HIC2 had two knee replacements in 1998.

HIC Number	Numerator Frequency of Selected Procedures - CABG	Numerator Frequency of Selected Procedures - Total Knee Replacement
HIC 1	**0**	**0**
HIC 2	**1**	**2**
HIC3	**0**	**0**
HIC 100	**0**	**1**

Inpatient Utilization - General Hospital/Acute Care

MCOs must report the total number of discharges and associated days for each beneficiary for each category. Note that HIC3 had two surgery discharges with a total of 12 associated days. Hypothetically, the first hospitalization may have lasted four days and the second may have lasted eight days. Similarly, HIC3 also had two medical hospitalizations in the reporting year with a total of four associated days. Note that the total discharges (4) and days (16) for HIC3 is the sum of the discharges and days from the other three categories: surgery, medicine, and maternity.

HIC Number	Numerator Discharges - Total	Numerator Days - Total	Numerator Discharges - Surgery	Numerator Days - Surgery
HIC 1	**0**	**0**	**0**	**0**
HIC 2	**2**	**8**	**1**	**5**
HIC3	**4**	**16**	**2**	**12**
HIC 100	**0**	**0**	**0**	**0**

.... continuation of Inpatient Utilization - General Hospital/Acute Care

HIC Number	Numerator Discharges - Medicine	Numerator Days - Medicine	Numerator Discharges - Maternity	Numerator Days - Maternity
HIC 1	**0**	**0**	**0**	**0**
HIC 2	**1**	**3**	**0**	**0**
HIC3	**2**	**4**	**0**	**0**
HIC 100	**0**	**0**	**0**	**0**

Use of Services - Ambulatory Care

MCOs must provide the total number of visits or stays for each beneficiary in each category.

HIC Number	Numerator Outpatient Visits	Numerator Emergency Room Visits	Numerator Ambulatory Surgery/ Procedures	Numerator Observation Room Stays Resulting in Discharge
HIC 1	**4**	**1**	**2**	**0**
HIC 2	**0**	**0**	**0**	**0**
HIC3	**2**	**1**	**0**	**0**
HIC 100	**6**	**0**	**1**	**1**

Use of Services - Inpatient Utilization - Nonacute Care

MCOs must provide the total number of discharges and associated days for each beneficiary. Again, the number of reported days should be the total number of days associated with each discharge. For example, HIC3 might have had 10 days associated with each of his three discharges, for a total of 30 days.

HIC Number	Numerator Nonacute Discharges	Numerator Nonacute Days
HIC 1	**0**	**0**
HIC 2	**1**	**17**
HIC3	**3**	**30**
HIC 100	**0**	**0**

Use of Services - Mental Health Utilization and Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay

MCOs must provide the total number of discharges and associated days for each beneficiary. Again, reported days should be the total number of days associated with the reported discharges. Like the Mental Health Utilization example below, MCOs must report inpatient discharges and days for Chemical Dependency Utilization.

HIC Number	Numerator MH Inpatient Discharges	Numerator MH Inpatient Days
HIC 1	**0**	**0**
HIC 2	**0**	**0**
HIC3	**1**	**8**
HIC 100	**2**	**14**

Use of Services - Mental Health Utilization and Chemical Dependency Utilization- Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Care

Like the Mental Health Utilization example below, MCOs must indicate both whether a member had any Chemical Dependency Utilization and, if so, where they received that care: inpatient, day/night, or ambulatory. For both the Mental Health and Chemical Dependency Utilization measures, if the "any" category has some mental health utilization (a "1" indicator) then at least one of the three numerator columns (inpatient, day/night, ambulatory) should have a value of “1.”

HIC Number	Numerator Mental Health Utilization - Any	Numerator Mental Health Utilization - Inpatient	Numerator Mental Health Utilization - Day/Night	Numerator Mental Health Utilization - Ambulatory
HIC 1	**1**	**0**	**0**	**1**
HIC 2	**0**	**0**	**0**	**0**
HIC3	**1**	**0**	**1**	**0**
HIC 100	**0**	**0**	**0**	**0**

Attachment III

HEDIS® MEASURES REQUIRED FOR AUDIT IN 1999

Effectiveness of Care

Antidepressant Medication Management
Cholesterol Management After Acute Cardiovascular Events
Breast Cancer Screening
Beta Blocker Treatment After A Heart Attack
Eye Exams for People with Diabetes

Access to/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services

Health Plan Stability

Practitioner Turnover

Use of Services

Frequency of Selected Procedures

Health Plan Descriptive Information

Board Certification (The Residency Completion portion of this measure is not required for audit in 1999.)

Attachment IV

ADDITIONAL INFORMATION ON THE MEDICARE HEALTH OUTCOMES SURVEY

1. Will the health plans have access to the members' data before 2001, as this could be key in quality improvement efforts?

A. Baseline Health Outcomes Survey data will be returned in the form of an aggregate, contract specific, performance profile (i.e., no patient-level information will be provided). Individual patient-level data will be provided after the 24 month follow-up survey in 2001.

2. Do we have an estimate of the range of cost for the Health Outcomes Survey?

A. Yes, the anticipated cost is approximately between $12 and $18 per fielded survey.

3. Can you clarify the 1,000 cohort drawn for the Health Outcomes Survey? In year two (1999) of the evaluation, will additional sampling be drawn if less than 1,000 enrollees can be contacted? And, will this occur again in 2000? When will the next cohort of 1,000 enrollees be drawn, in other words, will HOS reports come out each year after 2000 (e.g. requiring a new cohort be drawn in 1999 for reporting in 2001)? Due to the cost per survey, this is a particular budget issue for MCOs which may expect to pay for more than 1,000 surveys per year depending on the reporting schedule.

A. The diagram below indicates the current sampling strategy for the Health Outcomes Survey measure. Replacement of the 1,000 persons surveyed at baseline will not be necessary, as the 24 month follow-up does not anticipate a 100% response rate. It is anticipated that an entirely new cohort will be drawn every year so that the measure may be reported annually.

1998	**1999**	**2000**	**2001**
Baseline	Baseline	24 Month Follow-up	24 Month Follow-up
Cohort I- 1000	Cohort II - 1000	Cohort I	Cohort II
		New sample of 1,000 drawn for Cohort III	New sample of 1,000 drawn for Cohort IV

Since the technical expert panel will review the proposed specifications for the measure, this could change.

4. How will enrollee mortality be handled in reporting the results of the SF-36?

A. Beneficiaries who die between the baseline survey and 24 month follow-up are categorized in "worse" condition for reporting purposes.

5. Will HCFA risk adjust in its surveys?

A. We anticipate that the Health Outcomes Survey measure will be risk adjusted for age, race, sex, social support, co-morbid conditions, and normal expected decline in health status based on age.